DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			A. BUILDING 01, 02		1, 02	R	
1:		155693	B. WING			07/08/2014	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SILVER O	AKS HEALTH CAMPUS				011 CHAPA DR		
				С	COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	000} INITIAL COMMENTS		{K 0)00}			
	Code Recertification						
	Survey Date: 07/08/	14					
	Facility Number: 002 Provider Number: 15 AIM Number: 200340	55693					
	Surveyor: Mark Bugr Specialist	ni, Life Safety Code					
	was found in complia Participation in Medic Subpart 483.70(a), Li 2000 edition of the Na Association (NFPA) 1 and 410 IAC 16.2. Ti consisting of everythi	ng except the Transitional reyed with Chapter 19,					
	V (111) construction a facility has a fire alarm detection in the corric corridors and hard wi resident rooms. The facility has a capacity 69 at the time of this	dors, in spaces open to the red smoke detectors in all healthcare portion of the of 80 and had a census of survey.					
	were sprinkled. All a	reas which provide facility					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02		(X3) DATE SURVEY COMPLETED	
		4				R	
		155693	B. WING	B. WING		07/08/2014	
NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS				20	TREET ADDRESS, CITY, STATE, ZIP CODE 011 CHAPA DR OLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		BE COMPLETION	
{K 000}	Continued From page 1 services were sprinkled.		{K 0	{K 000}			
{K 000}		obert Booher, Life Safety ical Surveyor on 07/10/14.	{K 0	00}			
	Code Recertification a						
	Survey Date: 07/08/14 Facility Number: 002955 Provider Number: 155693 AIM Number: 200346570 Surveyor: Mark Bugni, Life Safety Code Specialist						
	was found in complian Participation in Medic Subpart 483.70(a), Li 2000 edition of the Na Association (NFPA) 1 and 410 IAC 16.2. Ti	Silver Oaks Health Campus nce with Requirements for care/Medicaid, 42 CFR fe Safety from Fire, and the ational Fire Protection 01, Life Safety Code (LSC) the Transitional Care Suites Chapter 18, New Health Care					
	V (111) construction a facility has a fire alarr detection in the corrid corridors and hard win resident rooms. The	was determined to be Type and was fully sprinkled. The m system with smoke dors, in spaces open to the red smoke detectors in healthcare portion of the of 80 and had a census of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION G 01, 02	COMPLETED			
		155693	B. WING _		R 07/08/2014			
NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2011 CHAPA DR COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC	NC		
{K 000}	69 at the time of this All areas where resid	survey. ents have customary access reas which provide facility	{K 00					